STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00090322. Complaint IN00090322-Substantiated. Federal/state deficiencies related to the allegation are cited at F157 and F309. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on April 18, 2011. Survey dates: May 31, 2011 Extended Survey dates: June 1 & 2, 2011 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Survey team: Janet Adams, RN, TC Lara Richards, RN Kathleen Vargas, RN Census bed type: SNF/NF: 78 Total: 78 Census payor type: Medicare: 4 Medicaid: 72 Other: 2	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total: 78 Sample: 15 Supplemental sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 8, 2011 by Bev Faulkner, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure timely physician notification related to increased blood pressure and respiratory rate and the need to alter a wound treatment for 2 of 15 resident reviewed for physician notification in the sample of 15. (Residents #C and #D)	F0157	**F 157** The ffacilitty will conttnue tto ensure ttmely nottffcattons tto tthe physician and legal representtattve when tthere is an accidentt involvving a residentt witth resultt in injury	06/24/2011

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	Findings include: The facility policy titled "Notification for Change in Resident Condition or Status" was received from the Assistant Director of Nursing on 6/2/11 at 9:45 a.m. The Assistant Director of Nursing indicated the policy was current. There was no date on the policy. The policy was reviewed at the above time. The policy indicated the facility staff were to notify the Physician of changes in the resident's medical/mental condition or status. The policy indicated the nurse supervisor/charge nurse was to notify the Physician of a significant change in the resident's physical, mental, or psychological condition or a need to alter the resident's medical treatment. 1. The closed record for Resident #C was reviewed on 6/2/11 at 7:45 a.m. The resident was admitted to the facility on 5/20/11. The resident's diagnoses included, but were not limited to, decubitus ulcer, colostomy, and paraplegia. The resident was sent to the hospital on 5/26/11 and was discharged from the facility. Review of the 5/20/11 Admission Nursing Assessment indicated the resident was admitted with a decubitus ulcer to the		as has tthe pottenttal ffor requiring physician intterventtons, a signiffcantt change off conditton in tthe residentt's physical, mentta, or psychosocial sttattus in eitther liffe tthreattening conditttons or clinical complicattons. **Correctve acton fior residents afiected:** R# C physician was nottffed off tthe wound vac nott be applied. R# C is no longer a residentt witthin tthe ffacilitty. R#D is no longer a residentt witthin tthe ffacilitty **How other residents will contnue to be identfied :** All currentt and newly admitted residentts who require physician nottffcattons will conttnue tto have tthe physician nottffed as needed. The License sttaff will documentt on tthe 24hr communicatton ttool when tthe physician is nottffed witth tthe reason ffor nottffcatton and itt	

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	right hip/thigh area. The wound measured 11 cm (centimeters) x 13 cm. The 5/20/11 Physician orders indicated there was an order to cleanse the right posterior thigh upper thigh with wound cleanser, pat dry, and apply wound vac. A care plan initiated on 5/20/11 indicated the resident had a pressure ulcer. Care plan interventions included to provide treatment as ordered by the physician. A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" sheet indicated the resident's right posterior thigh wound was present on admission on 5/20/11 and the wound was a stage IV (full thickness with exposed bone, tendon, or muscle present) pressure ulcer. The assessment indicated the current treatment was to be a wound vac. An entry made in the 5/20/11 Nurses' Notes at 7:45 p.m., indicated the resident had an area to the right posterior upper thigh that measured 11 cm x 13 cm x 4 cm and the wound bed was pink in color. A dressing was applied. An entry made in the 5/23/11 Nurses' Notes at 8:30 p.m., indicated wound vac initiated and functioning well. There was no documentation in the Nurses' Notes from 5/20/11 thru 5/23/11 at 8:30 p.m.		will be monittored by tthe Medical Records Directtor The License sttaff is tto nottffy tthe DON/Designee off any conditton changes. **System revision:** The license sttaff was in-serviced on 6-15-11 on proper physician nottffcatton **How the fiacility will monitor system:** The DON/Designee will auditt tthe minimal off 5 chartts and review tthe24hr communicatton sheett weekly off residentt who required nottffcattons tto assure compliance. The resultts off tthe auditt ttools will be discussed and reviewed witth recommendattons as needed by tthe intterdisciplinary tteam ffor tthree montths in tthe qualitty assurance meettngs tthen randomly tthrough tthe QA committee calendar dattes **Completon Date :** 6-24-11	

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	indicating the physician had been notified the wound vac was not applied as ordered on admission. Review of the 5/11 Treatment Record indicated the ordered treatment to cleanse the right posterior upper thigh with wound cleanser, pat dry, and apply wound vac was not signed out as completed 5/20/11 thru 5/25/11. When interviewed on 6/1/11 at 8:15 a.m., the Assistant Director of Nursing indicated the wound vac was ordered on Friday, 5/20/11. When interviewed on 6/1/11 at 1:30 p.m., the Assistant Director of Nursing indicated she spoke with the Nurse caring for the resident on admission and she indicated they did not receive the wound vac tubing. The Nurse also indicated she applied wet to dry dressing to the wound. The Assistant Director of Nursing indicated the Physician was not notified of the wound vac not being initiated upon admission as ordered. 2. The closed record for Resident #D was reviewed on 5/31/11 at 12:40 p.m. The Resident was admitted to the facility on 12/17/10. The resident's diagnosis included, but were not limited to, respiratory failure and tracheostomy.			

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The 12/10 Nurses' Notes were reviewed. The first entry was made on 12/17/10 at 2:15 p.m. This entry indicated the resident was admitted to the facility via an ambulance service. The resident's vital signs at this time were noted to be as follows:
Temperature: 98.1
Pulse: 82
Respirations: 36
Blood pressure: 138/102.
The next assessment of the resident's vitals signs was on 12/17/10 at 7:00 p.m. The resident's vital signs were as noted: Temperature: 98.8, Pulse: 73, Respirations: "rapid at 28", Blood Pressure: 180/92

The next entry in the 12/17/10 Nurses' Notes was on 12/17/10 at 11:30 p.m. This entry indicated the resident's respirations were 28 and rapid. There was no documentation of the resident's blood pressure or pulse rate.

The 12/18/10 Nurses' Notes were reviewed. The first entry was made at 12:30 a.m. There was no documentation of the resident's pulse or respiratory rates in this entry. The next entry was at 6:30 a.m. This entry indicated the resident's respirations were 24. The next entry was made at 2:15 p.m. This entry indicated

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	the resident's vital signs were as noted: Temperature: 99.3, Respiratory rate: 30, Pulse rate: 76. The next entry in the Nurses' Notes was at 2:15 p.m. This entry indicated the resident's vital signs were as noted: Temperature: 98, Blood Pressure: 130/90, Pulse: 90, and Respiratory Rate: 24. The next entry was made at 8:00 p.m. This entry indicated the writer was to start Cefepime 2 grams IV via the resident's right arm intravenous line. The entry also indicated the resident was noted to be tachypneic with respiratory rate of 40 and the resident's blood pressure was 150/100 and her pulse rate was 118. The next entry in the Nurses' Notes was made on 12/1910 at 1:00 a.m. This entry indicated the resident's blood pressure was 155/100 and her pulse rate was 119. There was no documentation in the above 12/17/10 or 12/18/10 Nurses' Notes indicating the Physician was notified of the resident's rapid respiratory and pulse rates, and elevated blood pressure reading. There was no documentation of resident receiving any of the ordered Vasotec, Flagyl, or Bactrim medications. When interviewed on 6/2/11 at 12:45 p.m., the Assistant Director of Nursing indicated the physician should have been notified of the resident's elevated blood			

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	pressure and respiratory rates. This Federal tag relates to Complaint IN00090322. 3.1-5(a)(2) 3.1-5(a)(3)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure the necessary treatment and services were provided related to arranging oral surgery consultations, and providing medications to treat infections and elevated blood pressures for 2 residents in the sample of 15. (Residents #F and #D) Findings include: 1. The record for Resident #F was reviewed on 5/31/11 at 10:45 a.m. A	F0309	**F309** The ffacilitty will conttnue tto provide tthe necessary care and services tto attain or mainttain tthe highestt practtcal physical, menttaJ and psychosocial well-being, in accordance witth tthe comprehensive assessmentt and plan off care **Correctve acton fior residents afiected:**	06/24/2011

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	Dental Referral Form, dated 4/1/11, indicated the resident was to be referred to Oral Surgery for tooth extractions. An entry in the Nursing Progress Notes, dated 4/29/11 at 1:50 p.m., indicated the resident had returned from "Kool Smiles" (the name of the dental facility). The resident's blood pressure was too high to receive services and a referral was made for the resident to go to an Oral Surgeon. The Oral Surgeons office was contacted and documentation indicated the scheduler would call the facility back. The next entry in the Nursing Progress Notes was not until 5/17/11 at 3:00 p.m. There was no additional information in the resident's record to indicate if Oral Surgery Services had been arranged. Interview with the Assistant Director of Nursing on 6/2/11 at 1:30 p.m., indicated the nurse who was setting up the appointment was no longer employed by the facility. She also indicated that when she contacted the Oral Surgeons office, she was told she would have to fax over the resident's information. The Assistant Director of Nursing indicated there was no information to indicate if an appointment had been arranged for the resident.		R #F physician was nottffed off tthe missed oral surgeon appointtmenttR# F was rescheduled tto see tthe oral surgeon on 6-30-11.. R#D is no longer a residentt witthin tthe ffacilitty **How other residents will contnue to be identfied :** A chartt auditt was conductted tto identtffy all currentt and newly admitted residentts who have outtside appointtmentts, inffecttons and a diagnosis off hyperttension **System revision:** The nursing sttaff was in-serviced on assuring proper care/services. The licensed sttaff is tto immediattely nottffy tthe DON/Designee off any conditton change. The Licensed sttaff will communicatte on tthe 24hr reportt sheett any residentt who has a change off conditton, a new diagnosis or a ffollow up appointtmentt. Any residentt who receives an order ffor	

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	2. The closed record for Resident #D was reviewed on 5/31/11 at 12:40 p.m. The Resident was admitted to the facility on 12/17/10. The resident's diagnosis included, but were not limited to, respiratory failure and tracheostomy. Review of the 12/17/10 admission Physician's orders indicated the resident		anttbiottc ttherapy new diagnosis or have a ffollow-up appointtmentt will be verbally communicatted DON/Designee. **How the fiacility will monitor system:** The DON/Designee will auditt 5 chartts weekly ffor compliance. The resultts off tthe auditts will be reviewed discussed witth recommendattons as needed by tthe intterdisciplinary tteam during tthe qualitty assurance meettng ffor tthree montths and tthen randomly tthrough tthe qualitty assurance ttopic calendar. Completton Datte 6-24-11	

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	was to receive oxygen per the tracheostomy at 8 liters continuously. There were also orders for the resident to receive Bactrim (an antibiotic) 20 millimeters per the PEG (percutaneous endoscopic gastrostomy) tube twice day, Flagyl (an anti-infective medication) 500 milligram per the PEG tube every eight hours. An order was also written for the resident to receive Cefepime (an antibiotic) 2 grams intravenously every twelve hours until 12/26/10. Orders were also written for the resident to receive Vasotec (a medication to lower blood pressure) 1.25 milligram per the PEG tube every six hours as needed for elevated blood pressure. There were no order for the resident to receive any scheduled routine cardiac medications for lowering blood pressure or heart rates. Review of the 12/10 Medication Administration Record indicated no doses of Vasotec 1.25 milligrams, Flagyl 500 milligrams, Bactrim 20 milliliters, or Cefepime 2 grams, medications were signed out as given. A hospital consultation report from the resident's hospitalization prior to being admitted to the facility was reviewed. The consultation report was in the resident's clinical record. The consultation report was dated 12/10/10. The report indicated			

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	infectious disease was asked to see the resident as the resident had a positive blood cultures and her c-difficile toxin was positive (indicating infection). Hospital laboratory results, dated 12/12/10, indicated the resident's c-difficile toxin remained positive. Results of a sputum culture collected in the hospital on 12/8/10 indicated the culture was positive for Acinetobactoer Baumannii (an infection) The 12/10 Nurses' Notes were reviewed. The first entry was made on 12/17/10 at 2:15 p.m. This entry indicated the resident was admitted to the facility via an ambulance service. The resident's vital signs at this time were noted to be as follows: Temperature: 98.1 Pulse: 82 Respirations: 36 Blood pressure: 138/102. The next assessment of the resident's vitals signs was on 12/17/10 at 7:00 p.m. The resident's vital signs were as noted: Temperature: 98.8, Pulse: 73, Respirations: "rapid at 28", Blood Pressure: 180/92 The next entry in the 12/17/10 Nurses' Notes was on 12/17/10 at 11:30 p.m. This entry indicated the resident's respirations were 28 and rapid. There was no			

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	documentation of the resident's blood pressure or pulse rate. The 12/18/10 Nurses' Notes were reviewed. The first entry was made at 12:30 a.m. There was no documentation of the resident's pulse or respiratory rates in this entry. The next entry was at 6:30 a.m. This entry indicated the resident's respirations were 24. The next entry was made at 2:15 p.m. This entry indicated the resident's vital signs were as noted: Temperature: 99.3, Respiratory rate: 30, Pulse rate: 76. The next entry in the Nurses' Notes was at 2:15 p.m. This entry indicated the resident's vital signs were as noted: Temperature: 98, Blood Pressure: 130/90, Pulse: 90, and Respiratory Rate: 24. The next entry was made at 8:00 p.m. This entry indicated the writer was to start Cefepime 2 grams IV via the resident's right arm intravenous line. The entry also indicated the resident was noted to be tachypneic with respiratory rate of 40 and the resident's blood pressure was 150/100 and her pulse rate was 118. The next entry in the Nurses' Notes was made on 12/1910 at 1:00 a.m. This entry indicated the resident's blood pressure was 155/100 and her pulse rate was 119. The entry also indicated orders were received and the resident was sent to the hospital emergency room for evaluation and treatment.			

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There was no documentation in the 12/17/10 or 12/18/10 Nurses' Notes indicating the Physician was notified of the resident's rapid respiratory and pulse rates, and elevated blood pressure reading. There was no documentation of resident receiving any of the ordered Vasotec, Flagyl, or Bactrim medications.

When interviewed on 5/31/11 at 1:50 p.m., an employee of the facility's contracted pharmacy indicated the resident's medications were filled on 12/18/10 and the deliveries leave the pharmacy around 1:00 or 1:30 p.m.

When interviewed on 6/2/11 at 12:45 p.m., the Assistant Director of Nursing indicated the resident's blood pressure was elevated and the prn (as needed) Vasotec could have been administered. The Assistant Director of Nursing indicated the resident's laboratory tests results indicated the resident had c-difficile and the ordered antibiotics should have been given in a timely manner. The Assistant Director of Nursing indicated the Physician was not notified of the resident's elevated blood pressure and respiratory rates.

This Federal tag relates to Complaint IN00090322.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-37(a)			